South Eastern School District
Delta-Peach Bottom Elementary School
Student Registration Packet

Please call 717-456-5313, ext.5800 to set up an appointment.

In addition to the completed Registration Packet, please bring along the following pieces of information:

- Two proofs of residency verifications (driver's license, lease, bill with printed address)
- Birth Certificate
- Immunization Record
- Grade Report from Previous School
- Custody Paper (if applicable)
- IEP or 504 Plan (if applicable)

South Eastern School District

Fawn Grove, Pennsylvania 17321

Student Registration/Census Form

For Internal Use Only

Grade: _____ **Enrollment Date:** ____/____/____ **Enrollment Code:** _____

Student ID #: _____ **Date of Withdrawal:** ____/____/____ **Date of Graduation:** ____/____/____

STUDENT INFORMATION

Student's Name: _____
(Last) (First) (Middle) (Jr., III, IV)

Address: _____
(Street) (City) (State) (Zip)

Township/Borough: _____ *Home Phone _____ *Cell Phone _____

Birth Date: ____/____/____ Place of Birth: _____ Gender: M F

Attendance Notification # _____

District Residence Date: ____/____/____ **PA Residence Date:** ____/____/____ **School Entry Date:** ____/____/____

Initial US Entry Date: ____/____/____ **(if ELL)**

School Last Attended (if applicable): _____

Address: _____

Phone: _____ **Fax:** _____

PARENT/GUARDIAN INFORMATION

1st CONTACT	2nd CONTACT	3rd CONTACT
_____ **Relationship to Student (ex. Father , Mother, Stepparent)**	_____ **Relationship to Student (ex. Father , Mother, Stepparent)**	_____ **Relationship to Student (ex. Father , Mother, Stepparent)**
Name:	**Name:**	**Name:**
Address:	**Address:**	**Address:**
***Home Phone:**	***Home Phone:**	***Home Phone:**
***Cell Phone:**	***Cell Phone:**	***Cell Phone:**
E-Mail Address:	**E-Mail Address:**	**E-Mail Address:**
Employer:	**Employer:**	**Employer:**
Address:	**Address:**	**Address:**
Occupation:	**Occupation:**	**Occupation:**
***Work Phone:**	***Work Phone:**	***Work Phone:**
Access to Student Info: Y N	**Access to Student Info: Y N**	**Access to Student Info: Y N**

***Enter "NA" after a telephone number to exclude it from the district's "School Reach" notification system.**

TRANSPORTATION INFORMATION

If Parent(s) Work, Babysitter's Name: _____

Babysitter's Address: _____

Babysitter's Telephone Number: _____

Provide location where child will board bus: _____

Bus Assigned: _____ **Bus Stop:** _____

LIST OTHER CHILDREN RESIDING AT PARENT/GUARDIAN ADDRESSES:

LAST NAME, FIRST NAME, MIDDLE NAME	DATE OF BIRTH	RELATIONSHIP TO PARENT/GUARDIAN	GENDER	RESIDES WITH	LAST SCHOOL ATTENDED	GRADE

IN ADDITION TO THOSE LISTED ABOVE, LIST OTHER INDIVIDUALS OVER THE AGE OF 18 RESIDING AT PARENT/ GUARDIAN ADDRESSES:

LAST NAME, FIRST NAME, MIDDLE NAME	RELATIONSHIP TO PARENT/GUARDIAN	OCCUPATION	PLACE OF EMPLOYMENT

TWO EMERGENCY CONTACTS (OTHER THAN PARENTS) FOR EMERGENCY SITUATIONS ONLY, NOT DAILY PICK-UP:

NAME and RELATIONSHIP	ADDRESS	PHONE

Family Physician _____ **Phone** _____

Family Dentist _____ **Phone** _____

Part 1: Ethnicity (choose one) Hispanic/Latino Not Hispanic/Latino

Part 2: Race: (choose one or more, regardless of ethnicity)

American Indian/Alaskan Asian Black or African American Native Hawaiian or Other Pacific Islander White

Student resides with: (Circle all that apply) Both parents Mother Father Joint Custody Parent & Stepparent Foster Parent Grandparent Agency Relative Children's Home Other*_____

***If student resides with other, indicate name and relation to the child:** _____

Status of adult with whom student resides: Single Married Separated Divorced Widowed Living Together

Date of most current Court Orders/Custody Decrees: _____

PLEASE PROVIDE A COPY OF ANY COURT ORDERS/CUSTODY DECREES THAT PERTAIN TO STUDENT OR RESTRICT ACCESS TO STUDENT.

Immigrant: Yes_____ No____ **Education in US School since _____ grade.**

(Not attend US schools more than 3 full years)

Home Language: _____

Has your child ever received remedial tutoring or special education services? Yes_____ No _____

If yes, please circle the type(s) below and provide dates of service: From: ____/____/____ To: ____/____/____

IEP:

Autistic	**Learning Support (LS)**	**Occupational Therapy (OT)**
Emotional Support (ES)	**Life Skills Support (LSS)**	**Physical Therapy (PT)**
Gifted Support (GIEP)	**Multiple Disabilities Support (MDS)**	**Hearing-Impaired Support (HIS)**
Vision Impaired Support (VIS)	**Speech/Language Support (SLS)**	**Neurologically Impaired Support (NI)**
Title I	**504 Plan/Service Agreement**	**Other:** _____

If the student is currently receiving services, please provide a copy of the program and the contact information.

_____

Parent/Guardian Signature

BIRTH RECORD VERIFICATION

BIRTHDATE:_____

BIRTHPLACE:_____

CERTIFICATE NO.:_____

STUDENT RESIDENCE VERIFICATION

TYPE OF VERIFICATION:_____

_____

South Eastern School District

Fawn Grove, Pennsylvania 17321

PROGRAMS FOR LIMITED ENGLISH PROFICIENCY STUDENTS
(Student Home Language Survey)

Date: _____

Student Name: _____
(First) (Middle) (Last)

School: _____

Date of Birth: _____ Age: _____

Address _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature:_____

1. Is your family and child's first language English? Check one of the following:
   Yes _____ (If yes, stop survey here)
   No _____ (If no, please continue survey

2. What language(s) does your child speak most often at home?_____

3. What language(s) do you use when speaking to your child? _____

4. What language(s) is spoken most often in your home?_____

5. What language(s) does your child read? _____

6. What language(s) does your child write? _____

7. Does your child understand, but not speak a language other than English?_____

Please list any other Schools your child has attended in the United States?

School	Years

The Civil Rights Law of 1964, Title VI requires that school districts/charter schools identify limited English proficient (LEP) students. Pennsylvania has selected the Home Language Survey as the method for the identification. <u>All</u> students enrolled in our District are required by the Pennsylvania Department of Education to complete the following survey. On behalf of your child, please complete and return to your child's school. Thank you for your assistance.

SESD: 55 (6/2013)

SOUTH EASTERN SCHOOL DISTRICT

377 Main Street
Fawn Grove, PA 17321

Permission to Release Student Information

PLEASE FORWARD THIS FORM OR A COPY WITH THE STUDENT RECORDS

For disciplinary records, please check the appropriate box:

☐ Certified disciplinary record enclosed ☐ Student has no disciplinary record

The signature of the following individual certifies the disciplinary records enclosed are the true and accurate discipline records of the student indicated below.

_____ _____ _____
School Official Position Date

PSC 1305-A: Requires the receiving school district in the state of Pennsylvania to request certified disciplinary records from a student's former school district. Please accept this form as a request for certified disciplinary records.

1. Student's Name _____ Grade _____ Date of Birth _____

Date enrolled at South Eastern School District _____

2. I hereby give permission for _____
(Name of Previous School)

to release the following information to South Eastern School District, for above-named student(s). It is my understanding that all information will be utilized only by professional personnel to aid my child in his/her education program.

_____ Title I
_____ Reading Recovery
_____ IST
_____ 504 Plan
_____ Other

_____ Psychological/Psychiatric Evaluations
_____ Comprehensive Evaluation Report (ER)
_____ Individual Educational Program (IEP)
_____ Notice of Recommended Educational Placement (NOREP)

_____ **Pa Secure ID #**

_____ Cumulative File Date
_____ Health/Dental/Immunization Records
_____ Discipline Records (weapons, drugs/ drug/alcohol, violence)
_____ Standardized Test Scores
_____ Report Cards or Grades to Date

_____ Mutual Exchange of Information (including school counselors, school nurse, teachers, and administrators)

_____ _____
Signature of Parent/Guardian/Surrogate Parent Date

IT IS NOT NECESSARY FOR PARENTS TO SIGN A RELEASE WHEN RECORDS ARE BEING PASSED FROM PUBLIC SCHOOL TO PUBLIC SCHOOL.
Note Federal Register, Part II HEW—Privacy Rights of Parents and Students. Vol: 41,#118-24673

"99.31 prior consent for disclosure not required"
(a) An educational agency or institution may disclose personally identifiable information from the education records of a student without the written consent of the parent of the student or the eligible student if the disclosure is (1) to other school officials, including teachers, within the educational institution or local educational agency who have been determined by the agency or institution to have legitimate educational interests; (2) to officials of another school or school system in which the student seeks or intends to enroll, subject to the requirements set forth in 99.34.

The above information is to be sent to:

☐ Delta-Peach Bottom Elementary School
1081 Atom Road
Delta, PA 17314
Fax - 717-456-6042

☐ Fawn Area Elementary School
504 Main Street
Fawn Grove, PA 17321
Fax - 717-382-1326

☐ Stewartstown Elementary School
17945 Barrens Road North
Stewartstown, PA 17363
Fax – 717-993-5256

☐ South Eastern Intermediate School
417 Main Street
Fawn Grove, Pa 17321
Fax 717-382-4786

☐ South Eastern Middle School
375 Main Street
Fawn Grove, PA 17321
Fax – 717-382-9033

☐ Kennard-Dale High School
393 Main Street
Fawn Grove, PA 17321
Fax – 717-382-4258

PLEASE FORWARD THIS FORM OR A COPY WITH THE STUDENT RECORDS

SESD: 45 (06/15)

SOUTH EASTERN SCHOOL DISTRICT

STUDENT RESIDENCY QUESTIONNAIRE

Dear Parent or Guardian,

Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren), and further help us determine if we have additional resources we can offer you and your family. Thank you for your cooperation.

1. Student Name:_____ Birth Date:_____

   Person completing form:_____ Relationship to child:_____

2. **In what type of setting is the student living now:**

   Check one box below –

SECTION A	SECTION B
☐ In an emergency or transitional shelter ☐ Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason ☐ In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations ☐ In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings ☐ Other places not designed for, or ordinarily used as, a regular sleeping accommodation for human beings CONTINUE to Section C if you checked any box in this section.	☐ None of the choices in Section A apply If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now, after signing the reverse side.

SECTION C

● What was the event that caused your family to move?

_____

● Do you consider this living situation to be a temporary situation, or something more long term?_____

Please
Explain:_____

_____

● When was the last day your son/daughter was enrolled in school?_____

3. Contact Number for the person completing this form:_____

4. The student lives with:

   Check all that apply
   □ Parent(s) or legal guardian
   □ Relative, friend(s), or other adult(s)
   □ Alone
   □ Other:_____

5. Contact person at school last attended (if known):_____

_____ _____

Signature of Parent/Legal Guardian ~ or individual enrolling child: Date

SOUTH EASTERN SCHOOL DISTRICT
Verification Under 24 P.S. 13-1304-A
Parental Registration Statement

I. Sworn Statement

Student Name _____

Date of Birth _____ Grade _____

Parent or Guardian Name _____

Address _____

_____ Telephone # _____

I hereby verify that my child has _____ or has not _____ been previously suspended or expelled from any public or private school in Pennsylvania or elsewhere for an act or offense involving **weapons, alcohol or drugs** or for the willful infliction of injury to another person or for any act of violence committed on school property.

I acknowledge that the foregoing statements are true and that the statements are made subject to the penalties of 18 Pa. C. S. §4904 (b) relating to penalties for unsworn falsifications to authorities.

_____ _____
(Signature of Parent or Guardian) (Date)

II. Supporting Information Complete this section if the child was previously Suspended or expelled for any offenses listed in Section I.

Name of School _____

Reason(s) for Suspension/Expulsion _____

_____

_____

Date of Suspension/Expulsion _____

_____

_____

South Eastern School District
New Entrant Student Emergency Card

Student Name: _____

Is your student covered by health insurance? __*Yes*__*No*
dental insurance? __*Yes*__*No*
vision insurance? __*Yes*__*No*

Potassium Iodide Program:

South Eastern School District participates in the Pennsylvania Department of Health Potassium Iodide (KI) program. Should a radiation emergency occur, the media would broadcast official recommendations to the public for protective actions including the possible use of KI. Distribution through the school system is being given high priority for the reason that children are much more sensitive to the ill effects of radioactive iodine than are adults. **KI should NOT be taken by anyone who is allergic to iodine.** A KI fact sheet is included in the Student Handbook or by contacting the Pennsylvania Department of Health at 1-877-PA-HEALTH or visiting the website at www.health.state.pa.us.

****Please place a check beside one of the following:**

` ___**YES,** I **DO** want my child to be given potassium iodide, when instructed by public health officials, in the event of a radioactive emergency during school hours.

South Eastern School District will make a reasonable attempt at supervising students taking the KI tablet, and will not be held liable for any adverse reactions to the KI tablet. I release the South Eastern School District, its administrators, employees, faculty, and staff from the voluntary participation of my child in the KI distribution effort.

___**NO,** I **DO NOT** want my child to be given potassium iodide, when instructed by public heath officials, in the event of a radioactive emergency during school hours.

PLEASE NOTE: The best protective action in a radiation emergency is evacuation.

Standing Order Medications:

School personnel have my permission to use the first aid supplies listed in the student handbook and the non-prescription medications listed below to treat my child as needed.

****Please check the items below that health room staff may give to your child during the school day.**

___ Antacid (liquid or tablet)*___ Generic Tylenol* ___ Cough Drops ___ Generic Advil/Motrin*

_____ Generic Zyrtec* (to treat allergy symptoms)

***All non-prescription medications listed above will be administered by (appropriate) weight or age.**

School personnel have my permission to transport or to make arrangements for transportation of my child to emergency medical care in the event that the persons listed cannot be contacted.

Parent/Guardian Signature: _____

PARENTS ARE RESPONSIBLE TO NOTIFY THE SCHOOL AS SOON AS POSSIBLE OF ANY CHANGES IN HEALTH, IMMUNIZATION STATUS OR CONTACT INFORMATION.

PLEASE TURN OVER TO FINISH COMPLETING INFORMATION

ANNUAL HEALTH HISTORY

Student Name:_____

TO THE PARENT OR GUARDIAN: The information requested on this form will be of help to the school nurse in determining the health status of your child. The information provided will be kept confidential and shared with school staff and bus drivers only when the school nurse and/or school physician believes that it is in the best interest of your child's health, safety and education. Please feel free to contact the school nurse if you have any questions or information you wish to share.

(CIRCLE YES or NO)

1. SHOULD YOUR CHILD BE RESTRICTED FROM PARTICIPATION IN SCHOOL SPORTS OR GYM? **YES / NO**

If yes, please provide recommendations from your physician, in writing.

2. DOES YOUR CHILD REQUIRE A SPECIAL DIET? **YES / NO**

*If yes, please specify*_____

3. HAVE THERE BEEN ANY CHANGES IN YOUR FAMILY DURING THE PAST YEAR WHICH MAY AFFECT YOUR CHILD? **YES / NO**

*If yes, please explain*_____

4. DOES YOUR CHILD

a) have trouble seeing? **YES / NO**

b) need to wear glasses/contacts lenses? **YES / NO**

If yes please X all that apply: ***Needed for Constant Wear_____ Near Vision_____ Distant Vision____***

c) have trouble with ears or hearing? **YES / NO**

d) need to wear hearing aids/amplification system? **YES / NO**

e) is preferential seating required? **YES / NO**

5. DO YOU HAVE ANY CONCERNS REGARDING YOUR CHILD TO DISCUSS WITH THE SCHOOL NURSE?
If yes, please call to set up an appointment. **YES / NO**

My signature below indicates that I have read and understand the information on both sides of this form.

_____ _____

Date Signature of Parent / Guardian

On behalf of the School Health Services, thank you for taking time to complete this important update of your child.

SOUTH EASTERN SCHOOL DISTRICT
K-6th Grade Student Health History

NAME OF CHILD	BIRTHDATE	GRADE

REQUIRED EXAMINATIONS

Pennsylvania State Law, under the School Health Code, requires:
* Physical Examination for original entry (Pre-K, K or 1st), Grades 6 & 11
* Dental Examinations for original entry (Pre-K, K or 1st), Grades 3 & 7

EXAMINATIONS

Physical Examinations: The School Health Act of Pennsylvania requires a physical examination for all children in grades 6 & 11, and all new students entering South Eastern School District whose records do not include a physical examination. This required exam may be dated one year prior to the start of school or sooner. Your family physician or school physician may meet the requirement.

_____ I plan to have my child's physical examination done by our family physician.

_____ Schedule my child's physical examination with the school physician.

Dental Examinations: The School Health Act of Pennsylvania requires a dental examination for all children in grades 3 & 7, and all new students whose records do not include a dental examination. This required exam may be dated one year prior to the start of school or sooner. Your family dentist or the school dentist may meet the requirement.

_____ I plan to have my child's dental examination done by our family dentist.

_____ Schedule my child's dental screening with the school dentist (complete a Mobile Dentist registration form).

SCREENING TESTS

Pennsylvania State Law, under the School Health Code, requires screening tests for: Growth & Vision (Pre-K-12), Hearing (Pre-K-3, 7 & 11) and Scoliosis (6 & 7). The School Nurse will complete these screening tests and inform parents/guardians of abnormal results.

IMMUNIZATION REQUIREMENTS:

A copy of your student's immunization record is required at time of registration.

Children in ALL grades (K-12) need the following vaccines:

TETANUS:*4 doses - 1 dose on or after 4th birthday
DIPTHERIA:* 4 doses – 1dose on or after 4th birthday
POLIO: 3 doses
MEASLES:** 2 doses
MUMPS:** 2 doses
RUBELLA:** 1 dose (German measles)
HEPATITIS B: 3 doses
VARICELLA: evidence of Immunity or 2 doses (chickenpox)

* Usually given as DTP, DT or Td
** Usually given as MMR

The only exemptions to the school law for immunizations are medical reasons, religious beliefs or philosophical/strong moral ethical convictions. An Immunization Exemption Form must be completed and on file at school. If your child is exempt from immunizations, he or she may be removed from school during an outbreak.

Does your child take any medication? Please Circle: No Yes Medication(s): _____

Is your child on any special treatments? (nebulizer, Epi-pen, catheterization, etc.) Please Circle: No Yes

Treatment(s) _____

Will your child need medication or treatment during the school day? Please Circle: No Yes

Medication(s):_____

Treatment(s):_____

All Medications and Treatments administered at school require a completed Authorization For Medication During School Hours form.

Signature of Parent/Guardian_____ Date _____

Reviewed by _____

Please complete side two of this form.

Please circle YES/NO If yes, please explain.

A. Pre-Natal Health History

1. Was the baby born prematurely? NO YES _____
2. Were there any complications during the pregnancy? NO YES _____
3. Did the mother take any medications/drugs during the pregnancy? NO YES _____

B. Developmental History

1. What was the baby's birth weight? _____
2. Did the baby have any concerns while in the hospital? NO YES _____
3. Did the baby have any special problems in the first six months? NO YES _____
4. Were there any concerns with the development of your child? NO YES _____
5. Were there any speech concerns with your child? NO YES _____
6. Can the child use the toilet without help? NO YES _____

C. Family Health History

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers or sisters have a history of:

Vision Problems Hearing Problems Learning Problems Social/Emotional Problems Other _____

2. Please share any concerns you have about your child's health or behavior: _____

Assessment of Student Health

To the best of your knowledge has your child had any problem with the following? Please check yes or no.

Condition	Yes	No	Comments
Allergic Reaction (Severe)			
Allergies (Food, Insect, Drugs, Latex)			
Allergies (Environmental, Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Chicken Pox Disease			
Cystic Fibrosis			
Developmental Problems			
Diabetes			
Ear or Hearing Problems			
Eating Disorders			
Eye or Vision Problems			
Growth Disorder			
Head Injury/Concussion			
Heart Problems			
High Blood Pressure			
Hospitalization (Why, When)			
Kidney/Urinary Problems			
Lead Poisoning/Exposure			
Limits on Physical Activity			
Meningitis			
Orthopedic/Bone Problems			
Seizures			
Sickle Cell Disease			
Speech Problems			
Stomach/Intestinal Problems			
Tumors/Cancer			
Other (Please Explain)			

Please contact the School Nurse if you have any concerns regarding your child that you would like to discuss.

Parent/Guardian Signature _____ Date _____

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ Phone_____

Signature of examiner_____ MD ☐ DO ☐ PAC ☐ CRNP ☐

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

_____
No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								**LEFT**								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

Sapphire - Parent Welcome Letter

The South Eastern School District implemented a new Student Information System called Sapphire in 2014-2015. This is a real-time integrated system that shares data between departments. Parents will be able to use one account to see attendance, schedules, grades, announcements and student information for all their children. We are able to provide you with more information and work toward becoming more paperless. Registration is easy and instructions are listed below:

If you registered last year, your account information and passwords stay the same and you will not need to register again.

Step 1: Prepare
You must have an email account in order to create an account. If you do not have an email account, there are many free email sites such as mail.yahoo.com and mail.google.com.

You will need to data enter the grades and birth dates of your children so they will be linked under one account.

Step 2: Create your parent account
***Any legal guardian who wishes to access the system should create an account.**

- Go to www.sesdweb.net
- Click Parent
- Click Sapphire
- Click Community Portal
- Click "Community Portal Application and Acceptable Use Policy Form"
- Enter keyword sesdsapphire
- Read the user agreement
- Click Yes
- Click Continue
- Enter applicant, children and login information.
- Click "Save Form and Continue"
- If desired, you may print a copy of the form for your records. You will automatically receive an email with your form details.

When your form is approved, you will receive an email notification with your pin. We anticipate approval will take up to five business days at the start of school year. Forms should be processed in less than 24 hours after the initial set of requests are processed. Record your username, password and pin and store it in a safe location.

Your account will remain active as long as you have children enrolled in the district. You do not need to create a new account each year.

Step 3: Log into Sapphire after you receive your pin

- Go to www.sesdweb.net
- Click Parent
- Click Sapphire
- Click Community Portal
- Enter username, password and pin.

Frequently Asked Questions:
If you forget your password, click on the "Forgot your password" link on the login page. Your password will be emailed to you.

If you forget your pin, email the Help Desk at techsupp@sesd.k12.pa.us or call 717-382-4843 x6333.

The user manual and any other related information can be found at the following link: http://www.sesdweb.net/sapphireparentinfo.